MISCELLANEOUS TEXT (FEC Form 99)

Freedom Committee, United States of America
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IDENTIFICATION NUMBER: C00547984
REFERENCE: 104.5(a). Quarterly Reports

To: FEDERAL ELECTION COMMISSION, WASHINGTON, D.C. 20463

Dear: Federal Election Committee,

While serving this great country and under the premise of the law as a physician/scientist and through my political fortitude, service obligations and in lieu of compensatory responsibilities see this and 104.5(a)quarterly report.

In regard to subject matter and last filing it is my belief a negative impact precludes a lack of cooperation and thus is evident in this report-

Payments to Providers

Before 1983, Part A payments to providers were made on a reasonable cost basis. Medicare payments for most inpatient hospital services are now made under a reimbursement mechanism known as the prospective payment system (PPS). Under the
PPS for acute inpatient hospitals, each stay is categorized into a diagnosis-related group (DRG). Each DRG has a specific predetermined amount associated with it, which serves as the basis for payment. A number of adjustments are applied to the DRG?s specific predetermined amount to calculate the payment for each stay. In some cases the payment the hospital receives is less than the hospital?s actual cost for providing the Part A-covered inpatient hospital services for the stay; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly inpatient hospital stays and other situations. Payments for skilled nursing care, home health care, inpatient rehabilitation hospital care, long-term care hospitals, inpatient psychiatric hospitals, and hospice are made under separate prospective payment systems.? No compensation has been received for myself as well as
several component and or supplemental programs of which I support.

For non-physician Part B services, home health care is reimbursed under the same prospective payment system as Part A; most hospital outpatient services are reimbursed on a separate prospective payment system; and most payments for clinical laboratory and ambulance services are based on fee schedules. A fee schedule is a comprehensive listing of maximum fees used to pay providers. Most DME has also been paid on a fee schedule in recent years but is paid based on a
competitive bidding process in some areas beginning January 1, 2011. This competitive bidding process will be expanded to all areas within the next several years.

As one would anticipate the following years to date bring formidable change and compensatory stability-but not without hardship, loss of life and hard work. Financial stability is of course a virtuous concept and one worth striving for. Through these concepts one should hope for stronger healthcare ethics and funding. To reiterate there is no change since last filing.

My encouraged comments, last filing/amendment regarding the states of North Carolina and Colorado, play a unique role in

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my furious discontent. One has tried to convey an absolute objective in regard to contractual environments all of which have not been paid. They remain delinquent in contract payments through normal business activities. One is entitled to prompt payment. This plays a subordinate role in healthcare thus a remarkable latent disposition for Medicaid and Medicare. This also constitutes millions of dollars, certainly a basis of which I could contribute to my own campaign contributions and also contribute to the continued growth of this Freedom Committee.

?In general, the prospective payment systems and fee schedules used for Part A and non-physician Part B services are increased each year either by indices related to the ?market basket? of goods and services that the provider must purchase or by indices related to the Consumer Price Index (CPI). These indices vary by type of provider. The Affordable Care Act mandates that these payment updates be decreased, in most cases, from what they would have been, by stipulated
amounts during 2010-2019, with starting dates and amounts varying by type of provider. In addition, payment updates are further reduced, on a permanent basis, by the growth in economy-wide productivity, with starting dates varying by type of provider, with some having started as early as October 2011. There is a strong likelihood that the lower payment increases will not be viable in the long range. The best available evidence indicates that most health care providers cannot improve their productivity to this degree due to the labor-intensive nature of most of these services.

If one could subjectively observe the above statement (Medicaid, Medicare Summaries) in regard to the ?evidence of which indicates that most heath care providers cannot improve their productivity to this degree due to the labor intensive nature of most of these services?, one should not balk but instead throw a ball to home plate and strike this it out.

These comments and aberrations of senseless suggestions need to be delineated not only in its written word but should be vigorously wrought and thrown out. When financial responsibilities come down to the actual dollars and cents in my opinion it is time to play hardball.

My reports and financial constructs due in fact prove not only profit but also methods of which to continue on an upward trek. No one can continue in a positive vein financially when there are apparent ambiguities in claims departments or through the ramifications of criminal behavior. When people do not commit to their mandatory work and continue to avoid it how does one maturate a healthcare system devised of miffed intentions? What I object to is the lack of cooperation at verification levels and proponent levels of which these obstacles pertain. I do not think it is funny to be mislead or misrepresented and object wholeheartedly to these stubborn intentions.

There are many very good programs and many hardworking people who work diligently on the edge of precedent and of whom
play integral roles in their vocations. In this report I am of course referring to Medical Providers and summaries of projected concept.

Since my last quarterly report in a fair and equitable United States I should have data to report-

From Actuarial Report Medicaid: ?The data and assumptions on which these Medicaid projections are based are derived from
four major sources. The first source is CMS data, which are submitted by the States to CMS on a regular basis.5 The States provide a quarterly report of spending by type of service; this report, known as the CMS-64, comprises expenditures for all Medicaid fee-for-service programs and capitation arrangements. The Medicaid Statistical Information System (MSIS) contains both service and demographic data supplied by the States, including provider payments and enrollment counts. The States also submit to CMS 2-year forecasts of spending

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by service, in a quarterly report known as
the CMS-37. Spending data are reported at both the Federal and State levels in the CMS-64 and CMS-37; MSIS expenditure data are reported as total Medicaid (Federal and State spending combined). OACT makes several adjustments to these data to merge them together for use in preparing projections.6

Lastly I wanted briefly comment regarding and including provider payments and enrollment counts: I have been waiting since 2012, upon Federal Licensing and for over a year as a physician and Medical Provider and as a Fiscal Agent for Medicaid and Medicare not only for my compensation but for numerous Medical Practices to move into active service. This includes the military and civilian practices. This also includes all the constructs which pertains to it and pharmacological, and thus dives deeper into Diversion systems such as the DEA and law enforcement. Many programs have
been at the brink of financial ruin or close therein only because the door to their participation has been closed. Doors swing both ways -and to this I do subscribe.

One can?t possibly explain how frustrating it is to be forced to wait based on bias and discrimination hidden in regulations, whereas it is individuals who choose to display their unalienable rights when they believe their opinion is formidable.

These unalienable rights do not feed people, these rights do not pay for emergency room visits or medicine; people do. These families such as my own have braved the forefront of tribulations due to a lack of coordination and communication and criminal event. All of us can improve in these areas and should not stop trying to become better people.

Together all of us may have to face fears far greater than ourselves and these evils, as it were, so often bring us closer somehow. Wouldn?t it be nice to come together to resolve these differences in opinions so we can all live together and thrive subsequent to one?s ambitions. This in turn will create a healthier and stronger country.

?A political committee is considered to have reason to expect it will exceed the electronic filing threshold for the next two calendar years after the calendar year in which it exceeds $50,000 in contributions or expenditures. Exception: This does not apply to an authorized committee with $50,000or less in net debts outstanding on January 1 of the year following the general election that anticipates terminating prior to January 1 of the next election year, as long as the candidate has not qualified under 2 U.S.C. ?432 as a candidate in the next election and does not intend to become a federal candidate in the next election. A new committee with no previous contributions or expenditures is considered to have reason to expect it will exceed the electronic filing threshold if it exceeds $12,500 in contributions or expenditures during the first calendar quarter of the calendar year, or $25,000 in contributions or expenditures in the first half of the calendar year.?

Everyone has a long way to go to achieve the General Election Limit:, or overall Primary Limit; of which to contrive languid and fluid participation's.

When contributions are submitted to this ?Freedom Committee? I will report it to the Federal Election Committee. This concludes the requests of information essential to full public disclosure of your federal election campaign finances, quarterly report.

In regard to 104.5(a), Quarterly reports-

This is my report to Congress; I am not required to report at this time, yet I ?or that has reason to expect to do so? I have not gained $50,000 in contributions, and I am still waiting for my compensation issues to be resolved and perhaps this campaign can start again in its pursuit of happiness.

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Thank you for your time.

Sincerely,

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IDENTIFICATION NUMBER: C00547984

Ref: Medicaid/Medicare Summaries.
Office of the Actuary

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